TESTIMONY OF

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BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON ENERGY AND COMMERCE

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Mr. Chairman, Members of the Subcommittee, I am thankful for the opportunity to meet with you today on behalf of the Department of Health and Human Services (HHS) to discuss the reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Background

The Ryan White CARE Act is a comprehensive approach to the provision of medical care, treatment, and support services to individuals living with HIV/AIDS who have no other means with which to obtain such care. The program is administered through the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS). The Federal Ryan White CARE Act was enacted in 1990; it was amended and reauthorized in 1996 and again in 2000. The authorization of appropriations expired on September 30, 2005. President Bush in his 2006 State of the Union Address stressed the importance of this program and asked Congress to, "reform and reauthorize the Ryan White Act and provide new funding to states so we end the waiting lists for AIDS medicines in America."

Since its last reauthorization, we have been able to provide antiretroviral treatment, primary care, and support services to over half a million people annually in the United States, Puerto Rico, Guam, the U.S. Virgin Islands, and eligible U.S. territories. In 2004, an estimated 65 percent of these individuals were racial minorities, 33 percent were women, and 87 percent were either uninsured or received public health benefits. The Ryan White CARE Act programs have provided important benefits to these populations. Overall, AIDS mortality is down and lives have been extended with HIV/AIDS medications purchased through the AIDS Drug Assistance

Program (ADAP). Pregnant women have been provided with care that has allowed them to give birth to children free from HIV infection, and thousands have received support services that have allowed them to access and remain in health care.

The structure of the Ryan White CARE Act allows for local flexibility and responsiveness in meeting diverse needs in different regions. It fosters collaboration among Federal, State, and local governments, and public and private entities to create a continuum of care for people living with HIV/AIDS.

The Ryan White CARE Act is organized into distinct program components. Title I provides emergency assistance to Eligible Metropolitan Areas (EMAs) that are most severely affected by the HIV/AIDS epidemic. To be eligible for Title I funding, an area must have reported at least 2,000 AIDS cases during the previous 5 years and have a population of at least 500,000.

Title II of the CARE Act provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and eligible U.S. territories. Title II grants support a wide range of care and support services. Title II also provides grants to States for Emerging Communities – that is, localities reporting between 500 and 1,999 AIDS cases over the most recent 5 years. Additionally, Title II funds the AIDS Drug Assistance Program (ADAP), which provides medications for the treatment of HIV disease.

Title III, Early Intervention Services (EIS), supports comprehensive primary health care and certain services for individuals who have been diagnosed with HIV. Services include education

to prevent transmission of HIV and case management to assure continuity of care. Title III grants expand the capacity of organizations providing primary care to indigent HIV-positive individuals. One third of all Title III grantees are community health centers.

Title IV provides community-based, family-centered services to women, children, and youth living with HIV and their families. Services include: primary and specialty medical care, psychosocial services, logistical support, outreach and case management.

The Ryan White CARE Act includes Part F – the Special Projects of National Significance (SPNS), the AIDS Education and Training Centers (AETCs), and the HIV/AIDS Dental Reimbursement Program. SPNS grants support innovative programs that hold promise for improving health outcomes. The AETCs provide education and training on a variety of topics for clinicians who treat people living with HIV/AIDS, with a focus on primary HIV care for underserved populations. The Dental Reimbursement Program assists accredited dental schools and postdoctoral programs with uncompensated costs incurred in providing dental treatment to patients with HIV infection. The Community Based Dental Partnership Program funds eligible entities in their efforts to increase access to oral health care and to support oral health service delivery and provider training in community settings.

Principles of Reauthorization

Last July, the Administration emphasized five key principles for reauthorization of the Ryan White CARE Act: (1) serve the neediest first; (2) focus on life-saving and life-extending services; (3) increase prevention efforts; (4) increase accountability; and (5) increase flexibility.

The President has made fighting the spread of HIV/AIDS a top priority of his Administration, and he will continue to work with Congress to encourage prevention, and the provision of appropriate care and treatment to those suffering from the disease. The President requested $2.08 billion for FY2006 and Congress appropriated $2.06 billion for the program. The President's FY2007 budget request for the CARE Act HIV/AIDS activities is $2.16 billion, an increase of $95 million for several elements of a new Domestic HIV/AIDS initiative (further elements of that initiative, focusing on testing in the areas of greatest need, are requested outside the CARE Act). The request will support a comprehensive approach to address the health needs of persons living with HIV/AIDS, consistent with the reauthorization principles. The budget also includes a new authority to increase program flexibility by allowing the Secretary to transfer up to five percent of funding provided for each Part of the Ryan White CARE Act to any other Part. Of the new $95 million requested, $70 million will address the on-going problem of State waiting lists and provide care and life-saving medications to those newly diagnosed as a result of increased testing efforts. The remaining $25 million will be used to expand outreach efforts by providing new HIV community action grants to intermediaries including faith and community-based organizations, and to provide technical assistance and sub-awards to grassroots organizations.

In order to serve the neediest first, objective indicators must be established to determine the severity of need for funding core medical services. The Secretary of Health and Human Services (HHS) would develop a severity of need for core services index (SNCSI). This index would be based upon objective criteria and be focused on core services. It would take into account

variables such as HIV incidence and prevalence, levels of poverty, and availability of other resources.

The Administration proposes focusing on life-saving and life-extending services by: establishing a set of core medical services; requiring that 75 percent of funds for Titles I, II, III and IV be spent on these core services; and maintaining a Federal list of core medications for the AIDS Drug Assistance Program (ADAP).

Requiring States to implement routine voluntary HIV testing in public facilities and working with private health care providers to implement testing will increase disease detection and further prevention efforts. With an estimated 250,000 HIV-positive individuals unaware of their HIV-positive status, testing is a key element in the Administration's prevention efforts. States will be encouraged to adopt important prevention strategies upon receipt of their Ryan White allocations.

Grantees are more likely to be held accountable if: States are required to submit HIV data; grantees are required to report on system and client –level data and progress; the payor-of-last-resort provision is strengthened; States coordinate HIV care and treatment with other federally funded programs to maximize efficiency and effectiveness; double counting of AIDS cases between eligible metropolitan areas (EMAs) and States is eliminated; and the "hold harmless" provisions are deleted.

Today, because of the way AIDS cases are counted, that is by including cases spanning the last 10 years, metropolitan areas with newer epidemics receive disproportionately less than those with more longstanding problems. In order to more accurately reflect the current status of the epidemic, the provisions that entitle cities to be "held harmless" from funding reductions should be eliminated.

Allowing the Secretary of HHS to redistribute unallocated balances based on the severity of need and allowing planning councils to serve as voluntary and advisory bodies to mayors will increase flexibility in the program. To maximize all CARE Act funding, unspent funds from Titles I and II would revert to the Secretary of HHS and the Secretary would extend those funds to ADAP programs or areas with the greatest need.

We can all be proud of the accomplishments of the Ryan White CARE Act and the dedicated people who make it work. The program has reached over 571,000 uninsured or underinsured persons affected by HIV/AIDS annually. Medication was provided to an estimated 138,834 persons living with HIV/AIDS in 2004. The program strives to reach those individuals who are the most in need of its services. Today, people with HIV/AIDS are living longer and healthier lives in part because of this Act. In order to make the legislation more responsive in the future, the Administration urges Congress to take into account the above stated principles in the reauthorization of the Ryan White CARE Act.

Thank you for the opportunity to discuss the Administration's principles for the reauthorization of the Ryan White CARE Act. We look forward to working with Congress throughout the reauthorization process.